Commentary

The Nonprofit Sector's Response to the AIDS Epidemic: Community-based Services in San Francisco

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Abstract: Community-based organizations in San Francisco have played a key role in providing social support services and public health information to those affected by acquired immune deficiency syndrome (AIDS). These services have helped minimize the economic impact of the epidemic by reducing the level and expense of hospitalization of AIDS patients. During fiscal year 1984–85, the three largest community-based groups in San Francisco provided more than 80,000 hours of social support and counseling services, responded to over 30,000 telephone inquiries and letters, and distributed nearly 250,000 pieces of literature. Home-based hospice care was provided to 165 AIDS patients at an average cost per day of $94 per patient.

Community-based organizations require a significant level of funding from government and private sources. Local government in San Francisco has provided 62 per cent of the revenues for these groups. At the same time, they are not viable without a steady stream of volunteer labor. More than 130,000 hours were donated this past year. There are intrinsic limits to the current dependency on unpaid labor and contributions made by private charity and local government which will eventually require increased support and intervention at the state and federal levels. (*Am J Public Health* 1986; 76:1325–1330.)

Introduction

Community-based organizations have played a key role in responding to the AIDS (acquired immune deficiency syndrome) epidemic. In the fall of 1984, a survey of 55 cities conducted by the United States Conference of Mayors reported that 60 per cent of local health departments had established working relationships with community-based organizations providing a number of AIDS-related services ranging from public health education to psychosocial counseling and housing for AIDS patients.[1] This paper examines the role of nonprofit community-based services in response to the epidemic in San Francisco, California which has experienced the second largest AIDS caseload in the world (next to New York City).

History

The total number of reported AIDS cases in San Francisco grew dramatically from 24 in 1981 to 1,631 through the end of 1985.[2] In 1982, the San Francisco Department of Public Health (SFDPH), through its Office of Lesbian and Gay Health, began to coordinate efforts to plan and develop services to meet the growing demands that the epidemic placed on the health care system. To avoid duplication of services and to coordinate the City and County's response (hereafter referred to as the City), a separate AIDS Activity Office was established within the SFDPH in 1983.[3]

The City has provided a substantial level of funding for a wide range of AIDS-related services. Funds have been allocated for epidemiological surveillance, assessments for medical care, home care, housing, psychosocial counseling, professional education, public health education, and risk reduction activities. Approximately $7.4 million in local funds were spent during fiscal year (FY) 1984–85 (July 1, 1984–June 30, 1985); $8.8 million is projected for FY 1985–86.[3]

The City chose to contract a number of services to community-based organizations; they included public health education, risk reduction strategies, psychosocial counseling, and home health care services. City funds provide a substantial percentage of the total revenues required by AIDS-related nonprofit groups.

The San Francisco AIDS Foundation (SFAF) was founded in April 1982 as a direct response to the AIDS epidemic. It began as an all-volunteer, grass roots organization composed mainly of gay community leaders and physicians. Initially located in a storefront with a single telephone, the group set up an Information and Referral Hotline that soon became nationally known as a source of accurate information on AIDS.

Beginning in October of 1982 and continuing to the present, the SFAF formally contracted with the San Francisco Department of Public Health (SFDPH) to provide educational services in San Francisco. These services include educational events, telephone services, materials development, and providing the media with accurate information on AIDS. In November 1983, the foundation contracted with the State of California Department of Health Services to provide information and referral services and educational programs to other counties in Northern California. The foundation established a social services department in 1983 to assist persons with AIDS and related conditions in need of emergency services such as shelter, financial assistance, and medical attention.

The Shanti Project was founded in 1974 by Dr. Charles Garfield, a research psychologist, and began as a nonprofit community-based organization to deal with the problems of death and dying. In the fall of 1981, its focus shifted to the AIDS epidemic. In December 1982, Shanti entered the first in a series of contracts with the SFDPH to provide counseling services and a housing program for persons with AIDS.

Hospice of San Francisco (Hospice) was formed in 1978 as a nonprofit corporation to provide physical, emotional, and spiritual care for terminally ill patients and their families

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TABLE 1—Social Support and Counseling Services Provided by Two Community-based Organizations: San Francisco, Fiscal Year 1984–85 (July 1–June 30)

Program	Units Provided*	People Served	Units per Person
Shanti Project			
Emotional Support	56,539	950	56
Practical Support	16,777	248	68
Inpatient Counseling (SF General Hospital)	6,138	1,260	5
Hospice			
Practical Support	1,820	n/a	n/a

*Counseling Units: number of hours spent in contact with clients—both individually and in groups—and in conference with staff/volunteers about specific client business.

in San Francisco County. In July 1983, it merged with two other existing nonprofit health care providers—the San Francisco Home Health Service, and the Visiting Nurse Association of San Francisco. Hospice is a subsidiary of its parent corporation, now known as the Visiting Nurse Association of San Francisco. In 1983 at the request of the San Francisco Board of Supervisors (the elected governing body), Hospice entered into a contract with the SFDPH to augment its existing programs to serve AIDS patients. By July 1984, a contract was negotiated to provide home health and hospice care to persons with AIDS. Under the terms of this contract, financing is per project rather than on a fee-for-service basis.

Services Provided by Organizations

Emotional Support/Counseling

The psychosocial needs of AIDS patients are extensive, complex, and unique.[4–6] Persons with AIDS and AIDS-Related Complex (ARC) are typically young men in the prime of their lives who were recently in good health and are poorly prepared to suddenly face a life-threatening illness. Over 90 per cent of all AIDS patients in San Francisco are between the ages of 20 and 49.[7] An AIDS diagnosis is a terrifying experience that raises a number of difficult issues that an AIDS patient must immediately face. These include reactions of employers, families, and friends, treatment options, sexual behavior modification, community fear and ostracism, financial hardship, physical deterioration, depression, and the fear of death itself.[8] Traditional health care systems have been unable or unwilling to develop an integrated approach to these areas of concern and have thus become the major focus of counseling interventions by community-based groups.

Emotional support and counseling services are provided by the Shanti Project whose trained professional and nonprofessional community volunteers offer free long-term counseling to persons with AIDS, their sexual partners, and their families. All counseling is done individually thus far, but the organization is also considering using a group counseling approach. Clients are matched to their counselors within 48 hours of their initial request. The meetings may take place at the client's home, the hospital or outpatient clinic, or any other agreed-upon setting, and they occur as frequently as is mutually suitable. During FY 1984–85, Shanti provided more than 56,000 hours of emotional support counseling to people affected by AIDS in San Francisco (Table 1).

As San Francisco General Hospital, the only acute care municipal hospital in the city, more than 6,000 hours were spent counseling AIDS patients and their visitors by Shanti's staff.

Practical Support

AIDS is a progressively debilitating disease which causes both functional impairment and physical dependency upon others.[9] At intermittent points throughout the disease cycle, normal activities such as cooking, cleaning, doing the laundry, shopping, and getting from one place to another become extremely difficult. The practical support programs of the Shanti Project and Hospice provide volunteers to help with these normal day-to-day activities. During FY 1984–85, Shanti and Hospice provided nearly 17,000 and 2,000 hours of practical support, respectively.

Home-based Hospice Care

During the course of the disease including the final days before death, there may be periods of time when hospital care is unnecessary and treatment at home desirable. Intermittent nursing and social work visits are inadequate to meet the multiple physical and psychosocial needs discussed earlier.* In addition, traditional home care under the Medicare structure generally does not meet the intense needs of persons disabled with AIDS because most patients are not eligible for Medicare.

Hospice's AIDS Home Care Program has organized a multidisciplinary team to provide health monitoring, skilled nursing, and other home health services which enable AIDS patients to maintain themselves at home. This team is comprised of registered nurses, medical social workers, home attendants (home health aides and homemakers), and volunteers, with contract services from physicians, therapists, and licensed vocational nurses when necessary. A broad range of services is available for those living independently and those in the terminal stages of their illness. During FY 1984–85, Hospice provided 7,764 days of home care to 165 different persons with AIDS (averaging 47 days per person).

Housing Services

Housing has been a particularly acute problem for persons with AIDS throughout the country.[10,11] Persons with AIDS have been displaced from their homes either because of financial difficulties relating to the burden of catastrophic illness or because of discrimination by landlords, family, or friends fearful of contagion.

By early 1983, increasing numbers of persons with AIDS were losing their homes and the Shanti AIDS Residence Program was established. This program operates low-cost independent housing for San Francisco residents with AIDS. Each tenant has a private bedroom and cooperatively runs the Residence. Although no direct health care services are provided by Shanti, home health care is available at the Residence through Hospice and other community providers. Shanti currently administers eight of these Residences. During FY 1984–85, 87 persons spent a total of 7,046 days in a Shanti Residence (averaging 81 days per person).

While long-term housing is handled by Shanti, emergency housing is provided by the San Francisco AIDS Foundation to persons with AIDS/ARC who have been displaced from their homes. Housing is available for up to two weeks during which time social workers assist clients in finding permanent housing.

*Martin JP, Schietinger H, Pratt S, Titus G: A model for providing comprehensive community-based care to people with AIDS; an alternative to institutional care. Paper presented at the annual meeting of the American Public Health Association; Washington, DC, November 1985.

TABLE 2—Educational Services Provided by Two Community-based Organizations: San Francisco, FY 1984–85

	Units Provided*	People Served
AIDS Foundation		
Telephone Services	9,968	9,470
Educational Events	128	11,500
Media Relations	507	n/a
Media Advertising	17	n/a
Materials Development and Distribution	240,872	n/a
Shanti Project		
Information and Referral	23,073	n/a

*Telephone Service Units: number of telephone calls received (San Francisco only).
Educational Events Units: number of forums, workshops and speaking engagements delivered.
Media Relations Units: number of media contacts about discrete issues with print and electronic media.
Media Advertising Units: number of original advertisements developed for placement.
Material Development/Distribution Units: number of pieces of literature distributed.
Information and Referral Units: number of telephone calls received, letters answered, and attendees at workshops and forums.

TABLE 3—Financial Status of Community-based AIDS Organizations in San Francisco: FY 1984–85

	AIDS Foundation	Shanti	Hospice
Total Program Expenditures	$1,094,928	$961,863	$726,179
Total Revenue	$1,245,182	$1,056,115	$696,212
Net Income (Loss)	$150,254	$94,252	($29,967)
Percentage Total Revenue by Source			
City and County of San Francisco	59	60	68
State of California			
Grants	7	—	—
Medi-Cal	—	—	5
Dept of Social Services	—	—	3
Federal			
Grants	5	—	—
Medicare	—	—	1
Private Contributions	29	40	13
Private Insurance	—	—	8
Patient Fees	—	—	2
Total	100	100	100

Data are based on audited financial statements for the Shanti Project and unaudited financial statements for Hospice of San Francisco and the AIDS Foundation.

TABLE 4—Hospice of San Francisco, Bad Debt by Source: FY 1984–85

	Bad Debt Dollars*	Per Cent Expected Revenue**
Private Insurance	$38,304	39.8
Medi-Cal	17,605	32.5
Medicare	500	10.3
Other	876	—
Total Bad Debt	$57,285	7.6

*Indicates uncollectible billing by source.
**Indicates the percentage of total billing that is uncollectible by source.

Public Health Education

In lieu of a vaccine, which could be many years away, effective public health education is the best known method to curb the transmission of AIDS. This includes disseminating information to high-risk groups about safe sex practices and the dangers of needle sharing, as well as promoting health activities that bolster the immune system, such as better nutrition, stress reduction, and exercise. The population outside the main risk groups needs information on transmission of the disease in order to reduce unwarranted fears, promote support for effective programs, and prevent further spread of the epidemic.

The paucity of federal resources devoted to public education efforts is of particular concern. During FYs 1984 and 1985, less than 4 per cent of all US Public Health Service AIDS funds were appropriated for information dissemination/public affairs.[12] Thus, much of the burden for providing public health education has been placed on local governments and community-based groups around the country.[1]

In San Francisco, public health education is largely the province of the AIDS Foundation, which works closely with the SFDPH, university scientists, and market researchers. There are five components to the education program at the AIDS Foundation: telephone services, educational events, media advertisements, media relations, and material development and distribution (Table 2).

A telephone hotline and a variety of educational events provide the public basic information about AIDS (such as symptoms, risk reduction guidelines, infection control precautions, treatment protocols, and side effects). Telephone referral services are also offered to physicians, screening clinics, and other organizations. Advertisements reach large numbers of people through the print and electronic media. In addition, considerable effort has been spent working with the media to ensure accurate reporting of the epidemic. The final component of the AIDS Foundation's educational services is developing and distributing detailed and informative brochures, flyers, and videotapes.

Social Services

Access to government programs has been facilitated by the social services program at the AIDS Foundation. Social workers act as liaisons between persons with AIDS and government bureaucracies at the Social Security Administration, General Assistance, and Food Stamp programs to ensure efficient application for benefits when necessary.

A privately funded food bank at the AIDS Foundation provides groceries for those in financial need. Disability benefits are the sole source of funds for many persons with AIDS/ARC. The food bank provides eligible persons with a weekly bag of groceries worth $25–30. At the present time, approximately 150 people use this service each month.

Financial Status of Community-based Groups

A detailed picture of the community-based groups' financing is given in Table 3. Clearly local government provides the bulk of support to these groups, with private donations the second largest source of funding. The latter come primarily from individual donors and fund-raising events and to a lesser extent from local business and foundation contributions.

This pattern of funding differs from non-AIDS related community groups in San Francisco. According to a recent study** of nonprofit health care organizations (exclusive of hospitals) in the San Francisco Bay Area, only 10 per cent of revenues came from private donations; 40 per cent came from government sources, primarily at the state and federal level.

It is worth noting that only Hospice, the most traditional health care provider of the three groups, suffered a net loss

**Urban Institute: The Nonprofit Sector Project, Washington, DC, unpublished data, 1985.

TABLE 5—Community-based Organizations, Staff Hours: San Francisco, FY 1984–85

	Volunteer Staff Avg Total Hours/Month	Paid Staff Avg Total Hours/Month	Ratio Vol/Paid Hrs
San Francisco AIDS Foundation	3,807	1,976	1.93
Shanti Project	6,852	3,900	1.76
Hospice	349	7,193*	0.05
All Non-Profit** Organizations SF Bay Area	690	1,725	0.40

*Approximately 40% of the paid staff hours in the Hospice program is provided by home health aides and homemakers.

**These data are shown for comparative purposes and are based on a sample of 366 non-profit organizations in the San Francisco Bay Area during 1982.

last year, because it relies on third party payers, particularly Medi-Cal (the state Medicaid program) and private insurers, who have been unwilling to reimburse home-based hospice care for AIDS patients adequately. Hospice wrote off more than $57,000 in uncollected bills (Table 4). Its net loss for the year ($30,000) could be expunged by improved reimbursements from third party payers. As of January 1986, the lack of adequate reimbursements from Medi-Cal, Medicare, and private insurance has forced the non-AIDS component of Hospice (which is not subsidized by the City) to place a moratorium on accepting new terminally ill patients into its program.***[13]

A comprehensive analysis of the viability of these organizations and the range of services they provide must include more than a narrow fiscal review of their expenses and revenues. Of fundamental importance to the survival of these groups is their extensive use of volunteer labor.

Volunteer Programs

Costs

In San Francisco, the AIDS Foundation and the Shanti Project rely heavily on donated labor. Hospice employs primarily paid staff. In Table 5, the magnitude of donated labor is reflected in the huge number of monthly volunteer hours, as well as in the ratios of donated to paid labor. The outpouring of support from the community to AIDS groups far exceeds the support given to other nonprofit organizations in the San Francisco Bay Area.

The sizable contribution of volunteers to these organizations and to the community can also be viewed in economic terms. In Table 6, upper and lower bound estimates are made of the economic values attributed to donated labor. The substantial economic valuations of unpaid labor represent a range of 30 to 84 per cent of the total annual dollar expenditures for the Shanti Project and 15 to 36 per cent of expenditures for the AIDS Foundation.

Training

The AIDS Foundation and the Shanti Project provide two different organizational models for the use of volunteers. At the AIDS Foundation, volunteers are seen as "staff extenders:" the paid professional staff is primarily responsible for the activities of the Foundation and volunteers assist them in carrying out their activities. At the Shanti Project, volunteers provide the bulk of services themselves, once they are adequately trained.

Volunteers in the Emotional Support Program of the Shanti Project must submit an application and be interviewed before being accepted for a 44-hour training. This training program includes overviews of the medical and psychological aspects of AIDS, substance abuse modification techniques, grief counseling specific to AIDS, alternative therapies and information on the services of other AIDS provider organizations. At the completion of the training, the volunteers make a commitment of six to eight hours weekly for six months. For two of these hours they participate in a support group that meets biweekly, where they receive feedback, guidance, and support. Practical Support volunteers' make a similar commitment after a mandatory 22-hour training which includes an AIDS medical overview, basic training on lifting and physically assisting compromised persons, group dynamics, assessing suicide risks and evidence of substance abuse that requires referrals, and use of role-playing to develop the necessary skills for helping clients.

Volunteers at Hospice to through a 16-hour training to orient them to basic hospice care and specifically for the care of AIDS patients. They are recruited and trained by the Volunteer Coordinator and attend weekly support groups. Home visits are supervised by the professional staff. In addition to the basic training, massage therapists, who are licensed practitioners, receive 30 hours of training in massage therapy, much of which is geared specifically to massage techniques for AIDS patients. All volunteers commit three to ten hours of their time per week for a minimum of one year.

At the San Francisco AIDS Foundation, 40 per cent of volunteer hours are spent staffing the telephone hotline which disseminates basic information on AIDS and makes referrals to specific AIDS programs and to physicians. The 10-hour hotline training program includes education in basic medical information and other topics that are likely to arise in calls and active listening skills. After the training, the volunteers are given a post-test and routine refresher sessions to keep their information up to date. Staff members and outside consultants periodically call the hotline to monitor the information being disseminated. All volunteers commit to work for a minimum of six to eight hours weekly for six months.

Discussion

The data presented above clearly indicate the indispensable role volunteers play in these AIDS organizations and the contribution they make to their community. Despite the base of financial support provided by local government funding and charitable donations, these organizations—with the exception of the Hospice program—are not viable without a continuous supply of unpaid labor. This raises a number of important issues.

Can the supply of people willing to donate their time and energies to the needs of those affected by AIDS match the expected growth of the epidemic? This question is crucial in areas of both high and low disease incidence. In New York and San Francisco, where AIDS has been concentrated and service demands have been the greatest, the pool of volunteers is generally drawn from the large, well-organized gay communities. However, it is logical to assume that the level of volunteer support will at some point reach its limit.

Recent evidence suggests that the epidemic is currently spreading faster outside the concentrated areas than within them.[14] In these low-incidence regions there may not be a significant at-risk population from which to draw a large pool of volunteers. Gaps in services which already exist in many of these communities may become more severe as the

***VNA of San Francisco: Hospice reorganizes in face of financial pressures, press release, January 3, 1986.

TABLE 6—Economic Value of Donated Labor, Community-based AIDS Organizations: San Francisco, FY 1984–85

	No. Volunteer Hrs	Rate$_1$*/Hr	$ Value	Rate$_2$**/Hr	$ Value
Shanti Project					
Emotional Support/Counseling	56,539	$3.35	$189,406	$11.50	$650,199
Practical Support	16,777	3.35	56,203	6.00	100,622
Information/Referral	910	3.35	13,049	8.25	7,507
AIDS Residence	8,000	3.35	26,800	6.00	48,000
Subtotal	82,226		285,458		806,328
San Francisco AIDS Foundation					
General Administration	2,990	3.35	10,017	8.25	24,668
Hotline	18,130	3.35	60,736	8.25	149,573
Educational events	5,490	3.35	18,392	8.25	45,293
Material Development/Distribution	4,510	3.35	15,109	8.25	37,208
Social Services	6,240	3.35	20,904	8.25	51,480
Food Bank	8,320	3.35	27,872	8.25	68,640
Subtotal	45,680		153,030		376,862
Hospice***					
Massage Therapy	600	15.00	9,000	25.00	15,000
Patient Care	1,820	3.35	6,097	6.00	10,920
General Administration	720	3.35	2,412	8.25	5,981
Subtotal	3,140		17,509		31,901
Total	131,046		455,997		1,215,091

*Rate$_1$ provides a lower bound hourly rate for donated labor. The minimum wage ($3.35/hour) is used for all programs except massage therapy which is provided by certified practitioners.

**Rate$_2$ provides an upper bound estimate (which may be conservatively low). These rates were derived as follows: emotional support counseling was pegged at the prevailing hourly rate for social workers used by the Hospice program; volunteers in the practical support and AIDS residence program at Shanti and patient care at Hospice were pegged to the prevailing rate for home attendant care; all positions at the AIDS Foundation, at the information and referral program at Shanti, and general administration at Hospice were pegged to an entry level secretarial position in San Francisco.

***The Hospice program began in October 1984.

epidemic progresses. Some cities have not only failed to provide adequate services but have shipped AIDS patients to San Francisco and other large metropolitan areas for treatment.[15,16]

Despite the invaluable contributions made by volunteers, many of the services needed by persons with AIDS can only be provided on a continuing basis by professionals. These include major aspects of hospital care, mental health, and social services. Persons with AIDS are as entitled to treatment by health care professionals as anyone with a debilitating and fatal illness.

Although Shanti, the AIDS Foundation and, to a lesser extent, Hospice rely upon a large supply of unpaid labor, they also depend on substantial financial support from local government and private sources. These funds have been used to build and maintain organizational structures with paid staff who recruit, train, supervise and support the volunteers. Other cities have expected volunteers to provide the bulk of these services themselves without a base of financial support, thus weakening their efforts and threatening the long-term viability of the organization.† In San Francisco, local government has provided the bulk of financial support to these groups during the early 1980s, a period of economic prosperity. The San Francisco budget surplus has now dwindled and it remains to be seen how long the City will continue to fund the expansion of community-based services to meet the needs of a still growing epidemic.

It has been argued that investing public funds in community-based services not only affords better quality care for persons with AIDS, but is also cost effective.[17,18] The fiscal argument rests primarily on two factors: 1) the hidden subsidy of large quantities of unpaid labor (volunteers) allows for a greater production of services per dollar expended than is possible if the City provided the services itself; and 2) the availability of community-based services is linked to reductions in the length and expense of hospitalizations for AIDS patients.

Reducing the overall rate of hospitalization at San Francisco General Hospital (SFGH) has a direct financial impact on the City and County of San Francisco. During 1984 the average length of stay for AIDS patients at SFGH was 11.7 days.†† This compares to stays of 17 days in Los Angeles,[19] 25 days in New York City,[20] and 52 days in Trenton, New Jersey.[21] SFGH has played the largest role of any health care facility in San Francisco in providing care for AIDS patients. However, reimbursements by third party payers (public and private) do not fully cover the cost of providing services to AIDS patients and approximately one-fourth of the patients have no health insurance coverage at all.††† As a result, local government tax revenues subsidize uncompensated care. Community-based services, which provide alternatives to costly hospitalizations, have thus been both rational fiscal policy and in the interests of patient care.

Furthermore, outpatient and inpatient services at SFGH are integrated with those provided by community-based groups. For example, counselors from Shanti, Hospice, and the AIDS Foundation work in the hospital itself and help

†Martin JP, Schjetinger H, Pratt S, Titus G: A model for providing comprehensive community-based care to people with AIDS; an alternative to institutional care. Paper presented at the annual meeting of the American Public Health Association, Washington, DC: November 1985.

††Scitovsky AA, Cline M, Lee PR: Medical care costs of AIDS Patients treated in San Francisco. Paper presented at the annual meeting of the American Public Health Association, Washington, DC, November 1985.

†††West Bay Hospital Conference: Monthly AIDS Hospital Utilization Report, unpublished data, October 25, 1985.

patients shorten their length of stay by arranging care for them outside the hospital. Hospital costs and length of stay are also reduced by the relatively low utilization of costly intensive care facilities at SFGH. According to the Scitovsky study,†† only 11 percent of SFGH's AIDS admissions spent one day or more in intensive care during 1984 which is probably lower than in other cities. This may reflect the role of Shanti counselors who educate patients about the course of their illness and the efficacy of technological life support systems, possibly resulting in patients' decisions to forgo intensive care in the terminal stages of their ailment.

Finally, the housing and home-based hospice care provided by community-based groups is far less expensive than inpatient hospitalization. In contrast to the ambiguous findings of other studies that measure the cost effectiveness of hospice care around the country,[22] the home-based program of Hospice of San Francisco provides unequivocal results. For the 165 AIDS patients served by Hospice during FY 1984–85, the average cost per patient per day was $94 and the total average cost per patient was $4,401. The Scitovksy study reported the average cost of hospitalization for AIDS patients at SFGH per day was $773, the average cost per hospitalization was $9,024, and the total lifetime cost for those patients who received all their hospital care at SFGH was $27,571. Hospitalizing AIDS patients is obviously necessary at times, particularly for acute medical episodes and intensive medical supervision, but often is unnecessary if patients can live where suitable home health care and social support services are available.

Conclusion

Community-based organizations have played a central role in responding to the AIDS epidemic. They have provided an important and otherwise missing dimension to patient care and social support services and have been instrumental in developing and disseminating public health information and prevention strategies. The marked drop in other sexually transmitted diseases among gay men in San Francisco[14] and the reported decline in high-risk sexual behavior associated with enhanced transmission of the AIDS virus[23] are undoubtedly due to some extent to the educational efforts of these groups.

It is argued that local government support of these community organizations is a rational fiscal response which helps to reduce the overall economic impact of the epidemic. However, this is based on the hidden subsidy of a large supply of unpaid labor from the community. In the past, health care expenditures were subsidized to a great extent by shifting the costs to public and private third party payers. In the current era of increased competition, prospective reimbursement, and pervasive attempts at cost containment, this has become increasingly difficult. The donations made by a large body of unpaid labor represent the final cost shift. If the epidemic continues to grow unabated there are intrinsic limits to the contributions made by local government, private charity, and unpaid labor. Under such conditions, pressures on local health care systems will mount, requiring substantial financial intervention at the state and federal levels.

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